. No. 2
—1-4-41
5-17-39
PI - X26390

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUL 28 1945

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 22680

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6270

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**1. PLACE OF DEATH:**

(a) County

(b) City or town Saint Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Christian Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 Days (Specify whether
In this community
years, months or days)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000 17 6

(c) City or town Saint Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3417a Belt Ave. 20 9
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Jack Umbright - Twin #2

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male 0

5. Color or race White

6. (a) Single, widowed, married, divorced 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased July (Month) 14 (Day) 1945 (Year)

8. AGE: Years | Months | Days 5 | If less than one day hr. min.

9. Birthplace Saint Louis (City, town, or county) Missouri 0 (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name John Albert Umbright
13. Birthplace Saint Louis (City, town, or county) Missouri 0 (State or foreign country)

MOTHER
14. Maiden name Ruth Jeanette Duignan
15. Birthplace Saint Louis (City, town, or county) Missouri 0 (State or foreign country)

16. (a) Informant Mrs Ruth Umbright
(b) Address 3417a Belt Ave. 20

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July (Month) 20 (Day) 1945 (Year)
(c) Place: burial or cremation New Picker Cem

18. (a) Signature of funeral director Calvin F Feutz Funeral Home
(b) Address 4828 Nat bridge Blvd

19. (a) JUL 20 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month July day 19
year 1945 hour 3 minute 15 P.M.

21. I hereby certify that I attended the deceased from Day of Birth July 14, 1945, to July 19, 1945, that I last saw him alive on July 19, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death Premature Infant And Small Twin

Due to Pylaric Stenosis

Due to

Other conditions
(Include pregnancy within 5 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] M.D. (M. D. or other)
Address 6804 W Florissant Date signed 7/19/45

(Licensed Embalmer's Statement on Reverse Side)

Not embalmed

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....Calvin F. Kientz

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**